		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0042481

Facility Name: ASPEN RIDGE CARE CENTRE

Address: 2530 NORTH MONROE STREET (Number) DECATUR (City) 62526 (Zip Code)

County: MACON

Telephone Number: (847) 875-0920 **Fax #** (847) 876-9351

IDPA ID Number: 36-4121314

Date of Initial License for Current Owners: 02/01/97

Type of Ownership:

[ ]	VOLUNTARY,NON-PROFIT	[X]	PROPRIETARY	[ ]	GOVERNMENTAL
[ ]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code ____		[ ]	Corporation	[ ]	Other ____
		[ ]	"Sub-S" Corp.		
		[X]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other ____		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2001 to 12/31/2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) SHAEL BELLOWS
(Title) MANAGEMENT CONSULTANT

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	204	Skilled (SNF)	204	74,460	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	204	TOTALS	204	74,460	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	9,170	1,273	5,275	15,718	8
9	SNF/PED					9
10	ICF	40,947	5,668	4,064	50,679	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	50,117	6,941	9,339	66,397	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.17%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 02/01/97

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 02/01/97 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 51 and days of care provided 4,235

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	240,068	24,937	14,886	279,891		279,891	1,875	281,766			1
2	Food Purchase		291,506		291,506		291,506	(2,187)	289,319			2
3	Housekeeping	255,179	34,777	0	289,956		289,956	(3,731)	286,225			3
4	Laundry	82,499	27,807	2,273	112,579		112,579	(3,143)	109,436			4
5	Heat and Other Utilities			156,956	156,956		156,956	0	156,956			5
6	Maintenance	77,732	50,082	53,535	181,349		181,349	(578)	180,771			6
7	Other (specify):*			15,393	15,393		15,393	0	15,393			7
8	**TOTAL General Services**	655,478	429,109	243,043	1,327,630	0	1,327,630	(7,764)	1,319,866			8
	B. Health Care and Programs											
9	Medical Director	0		38,400	38,400		38,400	0	38,400			9
10	Nursing and Medical Records	2,040,295	144,410	37,550	2,222,255		2,222,255	10,053	2,232,308			10
10a	Therapy	22,689		12,215	34,904		34,904	0	34,904			10a
11	Activities	137,252	5,768	3,430	146,450		146,450	(661)	145,789			11
12	Social Services	95,057		4,272	99,329		99,329	0	99,329			12
13	Nurse Aide Training			0	0		0	0	0			13
14	Program Transportation			260	260		260	0	260			14
15	Other (specify):*				0		0	0	0			15
16	**TOTAL Health Care and Programs**	2,295,293	150,178	96,127	2,541,598	0	2,541,598	9,392	2,550,990			16
	C. General Administration											
17	Administrative	99,191		535,800	634,991		634,991	(417,266)	217,725			17
18	Directors Fees			0	0		0	0	0			18
19	Professional Services			207,521	207,521		207,521	3,887	211,408			19
20	Dues, Fees, Subscriptions & Promotions			154,480	154,480		154,480	(114,059)	40,421			20
21	Clerical & General Office Expenses	138,967	37,657	79,752	256,376		256,376	119,705	376,081			21
22	Employee Benefits & Payroll Taxes			645,894	645,894		645,894	0	645,894			22
23	Inservice Training & Education			6,868	6,868		6,868	0	6,868			23
24	Travel and Seminar			1,670	1,670		1,670	12,771	14,441			24
25	Other Admin. Staff Transportation			13,145	13,145		13,145	0	13,145			25
26	Insurance-Prop.Liab.Malpractice			142,509	142,509		142,509	4,101	146,610			26
27	Other (specify):*			314,794	314,794		314,794	(314,794)	0			27
28	**TOTAL General Administration**	238,158	37,657	2,102,433	2,378,248	0	2,378,248	(705,655)	1,672,593			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,188,929	616,944	2,441,603	6,247,476	0	6,247,476	(704,027)	5,543,449			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number ASPEN RIDGE CARE CENTRE #0042481 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			54,048	54,048		54,048	53,859	107,907			30
31	Amortization of Pre-Op. & Org.				0		0	0	0			31
32	Interest			435,895	435,895		435,895	253,646	689,541			32
33	Real Estate Taxes			41,550	41,550		41,550	0	41,550			33
34	Rent-Facility & Grounds			633,000	633,000		633,000	(623,823)	9,177			34
35	Rent-Equipment & Vehicles			27,376	27,376		27,376	8,261	35,637			35
36	Other (specify):* STORAGE			2,887	2,887		2,887	0	2,887			36
37	**TOTAL Ownership**			1,194,756	1,194,756	0	1,194,756	(308,057)	886,699			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers		50,679	319,548	370,227		370,227	0	370,227			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			111,690	111,690		111,690	0	111,690			42
43	Other (specify):*				0		0	0	0			43
44	**TOTAL Special Cost Centers**	0	50,679	431,238	481,917	0	481,917	0	481,917			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,188,929	667,623	4,067,597	7,924,149	0	7,924,149	(1,012,084)	6,912,065			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(27,842)	30		9
10	Interest and Other Investment Income		32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,187)	2		13
14	Non-Care Related Interest	0	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees	0	20		17
18	Fines and Penalties	(1,820)	21		18
19	Entertainment	0	20		19
20	Contributions	(1,850)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers	(2,415)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(314,794)	27		24
25	Fund Raising, Advertising and Promotional	(103,454)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(11,065)	20		28
29	Other-Attach Schedule SEE PAGE 5A	(11,219)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (476,646)		$ 0	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(535,438)	PG 6,6A	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (535,438)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,012,084)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

ASPEN RIDGE CARE CENTRE

ID# 0042481

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 1372	6	1
2	VACATION ACCRUAL	1,875	1	2
3	VACATION ACCRUAL	(3,731)	3	3
4	VACATION ACCRUAL	(3,143)	4	4
5	VACATION ACCRUAL	(1,950)	6	5
6	VACATION ACCRUAL	(2,166)	10	6
7	VACATION ACCRUAL	(661)	11	7
8	VACATION ACCRUAL	(2,815)	21	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(11,219)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	1,875	0	0	0	0	0	0	0	0	0	0	1,875	1
2	Food Purchase	(2,187)	0	0	0	0	0	0	0	0	0	0	(2,187)	2
3	Housekeeping	(3,731)	0	0	0	0	0	0	0	0	0	0	(3,731)	3
4	Laundry	(3,143)	0	0	0	0	0	0	0	0	0	0	(3,143)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(578)	0	0	0	0	0	0	0	0	0	0	(578)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(7,764)	0	0	0	0	0	0	0	0	0	0	(7,764)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(2,166)	12,219	0	0	0	0	0	0	0	0	0	10,053	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(661)	0	0	0	0	0	0	0	0	0	0	(661)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(2,827)	12,219	0	0	0	0	0	0	0	0	0	9,392	16
	C. General Administration													
17	Administrative	0	(417,266)	0	0	0	0	0	0	0	0	0	(417,266)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,415)	5,927	375	0	0	0	0	0	0	0	0	3,887	19
20	Fees, Subscriptions & Promotions	(116,369)	2,310	0	0	0	0	0	0	0	0	0	(114,059)	20
21	Clerical & General Office Expenses	(4,635)	124,340	0	0	0	0	0	0	0	0	0	119,705	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	12,771	0	0	0	0	0	0	0	0	0	12,771	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	4,101	0	0	0	0	0	0	0	0	0	4,101	26
27	Other (specify):*	(314,794)	0	0	0	0	0	0	0	0	0	0	(314,794)	27
28	TOTAL General Administration	(438,213)	(267,817)	375	0	0	0	0	0	0	0	0	(705,655)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(448,804)	(255,598)	375	0	0	0	0	0	0	0	0	(704,027)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(27,842)	6,562	75,139	0	0	0	0	0	0	0	0	53,859	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	253,646	0	0	0	0	0	0	0	0	253,646	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	9,177	(633,000)	0	0	0	0	0	0	0	0	(623,823)	34
35	Rent-Equipment & Vehicles	0	8,261	0	0	0	0	0	0	0	0	0	8,261	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(27,842)	24,000	(304,215)	0	0	0	0	0	0	0	0	(308,057)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(476,646)	(231,598)	(303,840)	0	0	0	0	0	0	0	0	(1,012,084)	45

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED LIST OF OWNERS		SEE ATTACHED LIST OF RELATED		FIRST HEALTH CARE ASSOCIATES, LTD.		MANAGEMENT/
		NURSING HOMES		(DIVISION OF FHC ENTERPRISE, INC.)		CONSULTANT
					ROSEMONT	
				LANDMARK PROPERTIES		REAL ESTATE
					ROSEMONT, IL	

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	10	NURSING	$	FHC ENTERPRISES INC.		$ 12,219	$ 12,219	1
2	V	17	ADMINISTRATIVE	435,895	MR. BELLOWS OWNS 62.5% OF THIS FACILITY		18,629	(417,266)	2
3	V	19	PROFESSIONAL FEES		AND 100% OF FHC ENTERPRISES		5,927	5,927	3
4	V	20	DUES & SUBSCRIPTIONS		" "		2,310	2,310	4
5	V	21	CLERICAL		" "		124,340	124,340	5
6	V	24	TRAVEL		" "		12,771	12,771	6
7	V	26	INSURANCE		" "		4,101	4,101	7
8	V	30	DEPRECIATION		" "		6,562	6,562	8
9	V	34	RENT		" "		9,177	9,177	9
10	V	35	RENT-EQUIPMENT & VEH.		" "		8,261	8,261	10
11	V								11
12	V								12
13	V								13
14	Total			$ 435,895			$ 204,297	$ * (231,598)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	RENT	$ 633,000	LANDMARK PROPERTIES		$	$ (633,000)	15
16	V	19	OTHER PROFESSIONAL		" "		375	375	16
17	V	30	DEPRECIATION-BLDG/IMP		" "		61,333	61,333	17
18	V	30	DEPRECIATION - EQUIP/FURN		" "		13,806	13,806	18
19	V	32	INTEREST - MTG		" "		250,646	250,646	19
20	V	32	AMORTIZATION - MTG COST		" "		3,000	3,000	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 633,000			$ 329,160	$ * (303,840)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	RELATED PARTY - FHC ENTERPRISES INC.								$		1
2	SHAEL BELLOWS	MNGMT CNSLT.	ADMIN.	62.5%	SEE ATTACHED	2.5	13.21	SALARY	18,629	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 18,629		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: FHC ENTERPRISES INC.
Street Address: 10700 W. HIGGINS ROAD, STE 300
City / State / Zip Code: ROSEMONT, IL 60018
Phone Number: (847) 296-9625
Fax Number: (847) 298-0824

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	NURSING	PATIENT DAYS	501,904	10	$ 92,369	$ 92,369	66,397	$ 12,219	1
2	17	ADMINISTRATIVE	PATIENT DAYS	501,904	10	140,817	140,817	66,397	18,629	2
3	19	PROFESSIONAL FEES	PATIENT DAYS	501,904	10	44,800		66,397	5,927	3
4	20	DUES AND SUBSCRIPTIONS	PATIENT DAYS	501,904	10	17,462		66,397	2,310	4
5	21	CLERICAL	PATIENT DAYS	501,904	10	130,660		66,397	17,285	5
6	21	CLERICAL	DIRECT COSTS	1	1	107,055	107,055	1	107,055	6
7	24	TRAVEL	PATIENT DAYS	501,904	10	96,528		66,397	12,771	7
8	26	INSURANCE	PATIENT DAYS	501,904	10	30,995		66,397	4,101	8
9	30	DEPRECIATION	PATIENT DAYS	501,904	10	49,603		66,397	6,562	9
10	34	RENT	PATIENT DAYS	501,904	10	69,364		66,397	9,177	10
11	35	RENT-EQUIPMENT & VEH	PATIENT DAYS	501,904	10	62,438		66,397	8,261	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 842,091	$ 340,241		$ 204,297	25

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	RELATED PARTY - LANDMARK PROPERTIES						$	$			$	1
2	AMERICAN NATIONAL BANK		X	MORTGAGE	VARIES	02/97	3,150,000	3,030,909		PRIME+	250,646	2
3	LOAN COSTS		X	LOAN COSTS			3,250	250			3,000	3
4												4
5												5
	Working Capital											
6	AMERICAN NATIONAL BANK		X	WORKING CAPITAL	VARIES		450,000	750,000		PRIME +	52,557	6
7	RELATED PARTIES	X		WORKING CAPITAL	VARIES		3,120,000	0		PRIME +	383,338	7
8												8
9	TOTAL Facility Related						$ 6,723,250	$ 3,781,159			$ 689,541	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$ 0	$ 0			$ 0	14
15	TOTALS (line 9+line14)						$ 6,723,250	$ 3,781,159			$ 689,541	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 178,600	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 43,338	2
3. Under or (over) accrual (line 2 minus line 1).		$ (135,262)	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 176,812	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ ____ For 19 ____ Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 41,550	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1996		8
1997		9
1998		10
1999		11
2000	43,338	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2000 TAX BILL.

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME ASPEN RIDGE CARE CENTRE COUNTY MACON

FACILITY IDPH LICENSE NUMBER 0042481

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	04-12-03-251-011	NURSING HOME	$ 75,203.86	$ 43,337.82
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 75,203.86	$ 43,337.82

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 59,720 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 5

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	90,679		$	1
2					2
3	TOTALS	90,679		$ 0	3

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	204		1996		$ 807,175	$ 29,352	27.5	$ 29,352	$	$ 146,645	4
5			1997		14,949	543	27.5	543		2,422	5
6											6
7											7
8											8
	Improvement Type**										
9	RELATED PARTY LANDMARK PROPERTIES										9
10	FIRE DOORS/ALUMINUM SCREENS			1997	3,609	131	27.5	131		590	10
11	LANDSCAPING			1997	16,142	587	27.5	587		2,641	11
12	OUTDOOR SIGNS			1997	8,110	294	27.5	294		1,217	12
13	KITCHEN REMODELING-FLOORING/CONCRETE FOOTINGS			1998	18,381	670	27.5	670		2,337	13
14	FENCE			1998	2,350	201	15	235	34	822	14
15	ASPHALT PAVEMENT			1998	7,491	640	15	499	(141)	1,872	15
16	PAVEMENT			1999	4,975	181	27.5	181		445	16
17	INSULATING UNIT			1999	6,991	254	27.5	254		625	17
18	WALLCOVERINGS/TILES/BLOCK WALLS/CARPET			1999	126,568	4,602	27.5	4,602		11,314	18
19	AWNINGS			1999	7,939	289	27.5	289		710	19
20	CHUTE DOOR, PAINTING & PREP ALL ROOMS/FLR TUB			2000	64,400	21,467	3	21,467		32,200	20
21	INSTALLATION OF ALL DRAPERIES FOR 4 FLOORS			2001	7,828	559	7	559		559	21
22	PAINT&PREP. ROOMS ON FLOORS 4 AND 5			2001	9,525	680	7	680		680	22
23	REPAIR HOLES, STRIP, SEAL CRACKS IN PARKING LOT			2001	5,950	198	15	198		198	23
24	INSTALL 41 INSULATING WINDOWS - RESIDENT RMS			2001	2,974	212	7	212		212	24
25	VCT FLOORING-DINING RM & MAIN CORRIDOR			2001	7,165	512	7	512		512	25
26	REPLACE ELEVATOR DOORS			2001	3,742	68	27.5	68		68	26
27											27
28					ADJ. TO SL	(107)			107		28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,126,264	$ 61,333		$ 61,333	$ 0	$ 206,069	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 294,491	$ 41,494	$ 23,161	$ (18,333)	3-15 YRS	$ 90,043	71
72	Current Year Purchases	60,899	12,554	3,045	(9,509)	3-15 YRS	3,045	72
73	Fully Depreciated Assets				0			73
74	RELATED PARTIES	99,786	20,368	20,368	0		93,363	74
75	TOTALS	$ 455,176	$ 74,416	$ 46,574	$ (27,842)		$ 186,451	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$ 0		$	76
77							0			77
78							0			78
79							0			79
80	TOTALS			$ 0	$ 0	$ 0	$ 0		$ 0	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,581,440	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 135,749	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 107,907	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (27,842)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 392,520	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A - RELATED PARTY

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 19,876 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	FACILITY USE	99 DODGE DURANGO	$ 625.00	$ 7,500	17
18					18
19					19
20					20
21	TOTAL		$ 625.00	$ 7,500	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	Nurse Aide Competency Tests				0
9	TOTALS	$ 0	$ 0	$ 0	$ 0
10	SUM OF line 9, col. 1 and 2 (e)	$ 0			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 109,638	$		$ 109,638	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			10,207			10,207	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			142,864			142,864	4
5	Physician Care	39-3	visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-3	# of prescrpts			56,839			56,839	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	X-RAY, LAB, RENTALS, I.V. THERAPY Other (specify):	39-2					50,679		50,679	13
14	TOTAL			$		$ 319,548	$ 50,679		$ 370,227	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2001 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 9,723	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 37,820)	1,790,767		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	62,370		6
7	Other Prepaid Expenses	172,213		7
8	Accounts Receivable (owners or related parties)	281,639		8
9	Other(specify): EMPLOYEE LOANS	400		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,317,112	$ 0	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	1,838		12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	355,390		16
17	Accumulated Depreciation (book methods)	(206,447)		17
18	Deferred Charges	3,960		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 154,741	$ 0	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,471,853	$ 0	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 339,880	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	162,768		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	149,056		30
31	Accrued Taxes Payable (excluding real estate taxes)	24,932		31
32	Accrued Real Estate Taxes(Sch.IX-B)	176,812		32
33	Accrued Interest Payable	355,120		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	MANAGEMENT FEES	538,925		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,747,493	$ 0	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	6,517,834		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 6,517,834	$ 0	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 8,265,327	$ 0	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (5,793,474)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,471,853	$ 0	48

***(See instructions.)**

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (4,574,383)	1
2	Restatements (describe):		2
3	XXXXXXXX	6,805	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (4,567,578)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,225,896)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,225,896)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 0	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (5,793,474)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,695,268	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,695,268	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 0	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 0	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	0	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 0	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING COMMISSIONS	2,985	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,985	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,698,253	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,327,630	31
32	Health Care	2,541,598	32
33	General Administration	2,378,248	33
	B. Capital Expense		
34	Ownership	1,194,756	34
	C. Ancillary Expense		
35	Special Cost Centers	370,227	35
36	Provider Participation Fee	111,690	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,924,149	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,225,896)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,225,896)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** NO **If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,706	1,796	$ 50,284	$ 28.00	1
2	Assistant Director of Nursing	3,660	3,948	85,033	21.54	2
3	Registered Nurses	4,313	4,601	95,436	20.74	3
4	Licensed Practical Nurses	54,728	58,738	863,885	14.71	4
5	Nurse Aides & Orderlies	92,356	98,457	894,631	9.09	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,949	2,159	22,689	10.51	8
9	Activity Director	2,119	2,255	30,246	13.41	9
10	Activity Assistants	9,636	10,249	107,006	10.44	10
11	Social Service Workers	6,203	6,857	95,057	13.86	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	2,065	2,372	40,635	17.13	14
15	Cook Helpers/Assistants	25,073	26,449	199,433	7.54	15
16	Dishwashers					16
17	Maintenance Workers	4,815	5,233	77,732	14.85	17
18	Housekeepers	25,422	27,712	255,179	9.21	18
19	Laundry	7,845	9,348	82,499	8.83	19
20	Administrator	2,038	2,289	99,191	43.33	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,761	11,597	138,967	11.98	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	4,141	4,459	51,026	11.44	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	258,830	278,519	$ 3,188,929 *	$ 11.45	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	192	$ 14,886	1-3	35
36	Medical Director	360	38,400	9-3	36
37	Medical Records Consultant	60	2,170	10-3	37
38	Nurse Consultant	491	19,751	10-3	38
39	Pharmacist Consultant	168	1,599	10-3	39
40	Physical Therapy Consultant	168	6,519	10a-3	40
41	Occupational Therapy Consultant	128	5,696	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	40	3,430	11-3	44
45	Social Service Consultant	40	4,272	12-3	45
46	Other(specify) ALZ. DIRECTOR	128	4,967	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,775	$ 101,690		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
LISA TRUDEAU	ADMIN		$ 99,191
			0
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 99,191

B. Administrative - Other

Description	Amount
FIRST HEALTH CARE - MANAGEMENT FEE	$ 535,800
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 535,800

C. Professional Services

Vendor/Payee	Type	Amount
SEE SCHEDULE ATTACHED		$ 207,521
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 207,521

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 55,912
Unemployment Compensation Insurance	67,831
FICA Taxes	244,645
Employee Health Insurance	235,909
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	34,125
EMPLOYEE PHYSICAL EXAMS	5,860
PENSION/PROFIT SHARING PLANS	1,612
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 645,894

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	20,844
Health Care Worker Background Check	1,668
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	114,519
RELATED PARTY	2,310
CONTRIBUTIONS	1,850
DUES & SUBSCRIPTIONS	14,691
LICENSES & PERMITS	908
LESS: CONTRIBUTIONS	(1,850)
Less: Public Relations Expense	(0)
Non-allowable advertising	(103,454)
Yellow page advertising	(11,065)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 40,421

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
TRAVEL	1,670
RELATED PARTY	12,771
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 14,441

**See instructions.

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	PAINT/DECORATING	1998	$ 1,614	3	$ 269	$ 538	$ 538	$ 269	$	$	$	$	$
2	PAINT/DECORATING	1999	9,491	3		1,582	3,164	3,164	1,581				
3	PAINT/DECORATING	2000	3,437	3			572	1,146	1,146	573			
4	PAINT/DECORATING	2001	3,848	3				641	1,283	1,283	641		
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 18,390		$ 269	$ 2,120	$ 4,274	$ 5,220	$ 4,010	$ 1,856	$ 641	$	$

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? YES

(2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. ILLINOIS HEALTHCARE ASSOC. $11664

(3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ Line 10-2

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 111,690
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 0 Has any meal income been offset against related costs? N/A Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.

Facility Name & ID#: ASPEN RIDGE CARE CENTRE **#0042481** **Report Period Beginning: 01/01/2001** **Ending: 12/31/2001**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	14,886	
	REPAIRS & MAINTENANCE		0	
			0	14,886
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		2,273	
			0	2,273
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		56,048	
	ELECTRICITY		72,891	
	WATER		24,394	
	CABLE TV - LOBBY		3,623	
			0	156,956
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		11,917	
	PAINTING & DECORATING		3,848	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		10,794	
	ELEVATOR MAINTENANCE & REPAIR		8,940	
	OUTSIDE LABOR		2,157	
	EXTERMINATING SERVICE		8,400	
	FIRE SERVICE		4,770	
	DEFERRED MAINTENANCE		2,709	
			0	
			0	53,535
7	**OTHER**			
	SCAVENGER		14,967	
	SECURITY SERVICE		426	15,393
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	38,400	38,400

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		9,063	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTAN	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	2,170	
	PHARMACY CONSULTANT	XVIII B 39-2	1,599	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	19,751	
	ALZHEIMERS CONSULTANT	XVIII B 46-2	4,967	
			0	37,550
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	6,519	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	5,696	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	12,215
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	3,430	
			0	3,430
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	4,272	
			0	4,272
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number ASPEN RIDGE CARE CENTRE **#0042481** **Report Period Beginning: 01/01/2001** **Ending: 12/31/2001**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		260	260
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	535,800	535,800
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	19,033	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	188,488	
			0	207,521
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	103,454	
	EMPLOYEE WANT ADS	XIX F	20,844	
	CONTRIBUTIONS	VI 20 XIX F	1,850	
	DUES & SUBSCRIPTIONS	XIX F	14,691	
	LICENSES & PERMITS	XIX F	908	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	11,065	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	0	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	1,668	154,480
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES		35,382	
	EQUIPMENT REPAIR & MAINTENANCE		6,197	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	1,820	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		1,494	
	TELEPHONE		31,838	
	MESSENGER SERVICE		3,021	
			0	79,752

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	244,645	
	UNEMPLOYMENT COMPENSATION	XIX D	67,831	
	WORKERS COMPENSATION INSURANC	XIX D	55,912	
	HOSPITALIZATION INSURANCE	XIX D	235,909	
	EMPLOYEE BENEFITS - OTHER	XIX D	34,125	
	EMPLOYEE PHYSICAL EXAMS	XIX D	5,860	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	1,612	
	CHICAGO HEAD TAX	XIX D	0	645,894
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		6,868	6,868
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	1,670	
			0	
			0	1,670
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		13,145	13,145
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		142,509	142,509
27	**OTHER**			
	BAD DEBTS	VI 24	314,794	
			0	314,794

GRAND TOTAL COLUMN 3 OTHER 2,441,603

ASPEN RIDGE CARE CENTRE
EMPLOYEE MEAL RECLASSIFICATION
12/31/2001

TOTAL FOOD PURCHASE	291,506	PATIENT MEALS	199191
LESS SALES TAX	(2,187)	ADD EMPLOYEE MEALS	0
NET FOOD	293693	TOTAL MEALS/YEAR	199191
TOTAL PATIENT CENSUS	66,397	NET FOOD	293693
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	199191
TOTAL PATIENT MEALS	199191	COST PER MEAL	1.47
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY	0	EMPLOYEE MEAL RECLASSIFICATION	0
TIME # DAYS	365		
TOTAL EMPLOYEE MEALS	0		

ASPEN RIDGE CARE CENTRE
RECONCILIATION OF COST REPORT TO FINANCIAL STATEMENTS
12/31/2001

INCOME PER F/S									6,327,270	
	NURSING	EMPL BENEFITS	PLANT	LAUNDRY	DIETARY	GENL/ADMIN	OTHER INC/EXP	CAPITAL		SALARIES
PER COST REPORT	2,541,598	645,894	643,654	112,579	571,397	1,732,354	111,690	1,194,756		3,188,929
ADJUSTMENTS:										
EQUIPMENT RENTAL/AUTO LEASE	6,777		7,453			13,146		(27,376)		
CABLE TV			(3,623)			3,623				
CONTRACT NURSING										
INTEREST INCOME							0			
NET VENDING COMMISSIONS							(2,985)			
EMPLOYEE PHYSICAL EXAMS		(5,860)				5,860				
INSURANCE - EXECUTIVE LIFE		0				0				
MANAGEMENT FEES						(535,800)		535,800		
RESIDENT TAX REBILLED - PVT										
BAD DEBTS						(314,794)	314,794			
DISCOUNTS LOST							0			
AMORT-COMP SOFTWARE								0		
SETTLEMENT INTEREST										
RECLASSED SALARIES	(50,111)	0	0	0	0	50,111	0	0		
PROFIT SHARING	0	0	0	0	0	0	0	0		
PRIOR EXPENSES	0	0	0	0	0	0	2,229	0		
BENEFITS REBILLED	0	0	0	0	0	0	0	0		
RENT/INTEREST	0	0	0	0	0	(129,656)	0	129,656		
NURSE AID REIMB-STATE	0	0	0	0	0	0	0	0		
TOTAL COSTS	2,498,264	640,034	647,484	112,579	571,397	824,844	425,728	1,832,836	7,553,166	3,188,929
PER FINANCIAL STATEMENTS	2,498,264	640,034	647,484	112,579	571,397	824,844	425,728	1,832,836	(1,225,896)	3,188,929
NET INCOME (LOSS) BEFORE INCOME TAXES PER FINANCIAL STATEMENTS									1,225,896	

ASPEN RIDGE CARE CENTRE - COMPARISONS - 12/31/2001

	ref.	12/31/2001			12/31/2000			DIFF	12/31/1999		
CAPACITY DAYS		74,460			74664			(204)	74460		
CENSUS DAYS		66,397			63467			2,930	63348		
OCCUPANCY %		89.17%			85.00%				85.08%		
SALARIES											
TOTAL General Services	8-1	655,478	9.48%	9.87	543875	10.41%	8.57	111,603	502863	9.77%	7.94
Social Services	12-1	95,057	1.38%	1.43	80688	1.54%	1.27	14,369	73676	1.43%	1.16
TOTAL Health Care and Programs	16-1	2,295,293	33.21%	34.57	1919851	36.75%	30.25	375,442	1881592	36.56%	29.70
Clerical & General Office Expenses	21-1	138,967	2.01%	2.09	92787	1.78%	1.46	46,180	89068	1.73%	1.41
TOTAL General Administration	28-1	238,158	3.45%	3.59	184824	3.54%	2.91	53,334	174740	3.40%	2.76
TOTAL Operation Expense	29-1	3,188,929	46.14%	48.03	2648550	50.70%	41.73	540,379	2559195	49.73%	40.40
ADJUSTED TOTALS											
Food	2-8	289,319	4.19%	4.36	249909	4.78%	3.94	39,410	230798	4.49%	3.64
Heat and Other Utilities	5-8	156,956	2.27%	2.36	152377	2.92%	2.40	4,579	131144	2.55%	2.07
Maintenance	6-8	180,771	2.62%	2.72	143531	2.75%	2.26	37,240	131433	2.55%	2.07
TOTAL General Services	8-8	1,319,866	19.10%	19.88	1155304	22.11%	18.20	164,562	1071208	20.82%	16.91
Administrative	17-8	217,725	3.15%	3.28	113839	2.18%	1.79	103,886	101482	1.97%	1.60
Directors Fees	18-8	0	0.00%	0.00				0			
Professional Services	19-8	211,408	3.06%	3.18	225773	4.32%	3.56	(14,365)	186232	3.62%	2.94
Fees, Subscriptions, Promotions	20-8	40,421	0.58%	0.61	24115	0.46%	0.38	16,306	17511	0.34%	0.28
License Fee-IDPA	Pg21	0	0.00%	0.00	200	0.00%	0.00	(200)	200	0.00%	0.00
License Fee-Other	Pg21	908	0.01%	0.01	388	0.01%	0.01	520	668	0.01%	0.01
Clerical & General Office Expenses	21-8	376,081	5.44%	5.66	293026	5.61%	4.62	83,055	310090	6.03%	4.90
Employee Benefits & Payroll Taxes	22-8	645,894	9.34%	9.73	435239	8.33%	6.86	210,655	483112	9.39%	7.63
Payroll Taxes	Pg21	312,476	4.52%	4.71	286700	5.49%	4.52	25,776	259473	5.04%	4.10
W/C Insurance	Pg21	55,912	0.81%	0.84	42779	0.82%	0.67	13,133	49490	0.96%	0.78
Health Insurance	Pg21	235,909	3.41%	3.55	81286	1.56%	1.28	154,623	162879	3.17%	2.57
Inservice Training & Education	23-8	6,868	0.10%	0.10	6886	0.13%	0.11	(18)	6984	0.14%	0.11
Travel and Seminar	24-8	14,441	0.21%	0.22	12600	0.24%	0.20	1,841	9998	0.19%	0.16
Other Admin. Staff Transportation	25-8	13,145	0.19%	0.20	5966	0.11%	0.09	7,179	6277	0.12%	0.10
Insurance-Prop.Liab.Malpractice	26-8	146,610	2.12%	2.21	93948	1.80%	1.48	52,662	45792	0.89%	0.72
Other (specify):*	27-8	0	0.00%	0.00				0			
TOTAL General Administration	28-8	1,672,593	24.20%	25.19	1211392	23.19%	19.09	461,201	1167478	22.69%	18.43
TOTAL Operation Expense	29-8	5,543,449	80.20%	83.49	4525384	86.62%	71.30	1,018,065	4414329	85.78%	69.68
Real Estate Taxes	33-3	41,550	0.60%	0.63	45600	0.87%	0.72	(4,050)	45600	0.89%	0.72
Real Estate Legal	Pg10	0	0.00%	0.00				0			
GRAND TOTAL COST	45-8	6,912,065	100.00%	**104.10**	5224119	100.00%	**82.31**	1,687,946	5145894	100.00%	**81.23**
8-8 + (28-8 - 22-8) + 28-8*(8-1 + 28-1)/29-1		2527564.37	36.57%	**38.07**	2051205	39.26%	**32.32**	476,359	1883488	36.60%	**29.73**

ASPEN RIDGE CARE CENTRE - DIAGNOSTICS - 12/31/2001

This report reflects a 365-day year.

Page 3 Column 3 - Other is completely scheduled.

Total Salaries on Page 3 Line 29-1 = Page 20 Line 34-3.

Total Adj on Page 4 Line 45-7 = Page 5 Line 37.

Deferred maint. adj. on Page 5A Line 1 consists of 5220 from Page 22 and -3848 from Page 3 Line 6-3.

Ancillaries on Page 4 Line 39-6 = Page 16 Line 14-8.

Interest Expense on Page 4 Line 32-4 DOES NOT EQUAL Page 9 Line 15-10. Diff=-253646

Real estate tax expense on Page 4 Line 33-4 = Page 10 Line 7.

Real estate tax accrual on Page 10 Line 4 = Page 17 Line 32-1.

Depn expense on Page 4 Line 30-4 DOES NOT EQUAL Page 13 Line 82-2. Diff=-81701

Depreciation expense on Page 4 Line 30-8 = Page 13 Line 83-2.

Facility rent on Page 4 Line 34-4 DOES NOT EQUAL Page 14 Line 7-4.

Equipment rent on Page 4 Line 35-4 = Page 14 Line 16 + Line 21-4.

Nurse aide training on Page 3 Line 13-8 = Page 15 Line 9-4.

Total equity on Page 17 Line 47-1 = Page 18 Line 24-1.

Page 17 Assets = Liabilities & Capital.

Net income on Page 18 Line 7-1 = Page 19 Line 43-2.

Administrative Salaries on Page 3 Line 17-1 = Page 21-A.

Management fees on Page 3 Line 17-3 = Page 21-B.

Professional fees on Page 3 Line 19-3 = Page 21-C.

Employee benefits/Payroll taxes on Page 3 Line 22-8 = Page 21-D.

Dues, etc. on Page 3 Line 20-8 = Page 21-F.

Travel expenses on Page 3 Line 24-8 = Page 21-G.